GREEN RIVER DENTISTRY

PATIENT REGISTRATION – CHILD

First Name _____ **Last Name** _____ **M.I.** _____

Today's Date _____/_____/_____ **Date of Birth** _____/_____/_____

Primary Address (where the child resides) _____
(no P.O. boxes please)

City _____ **State** _____ **Zip Code** _____

Primary Phone Number _____ **Cell** _____ **Text:** Y **or** N

Primary Email Address _____ **Email:** Y **or** N

With whom does the child reside: _____

Billing Address (if different) _____

City _____ **State** _____ **Zip Code** _____

Phone Number _____**Cell** _____ **Text:** Y **or** N

Email Address _____ **Email:** Y **or** N

Father and/or Guardian

First _____ MI _____ Last _____ DOB ____/____/_____

Home Phone _____ Cell Phone _____

Work Phone _____ Email _____

Mother and/or Guardian

First _____ MI _____ Last _____ DOB ____/____/_____

Home Phone _____ Cell Phone _____

Work Phone _____ Email _____

Who may we thank for referring you to our office? _____

TREATMENT AUTHORIZATION

for patients age 18 and under

We must have permission from a child's parent or guardian before providing medical services when the child is accompanied by someone other than the parent or legal guardian or presents by him or herself. If you feel there may be an occasion where your child will be brought by a relative, sitter, etc. please fill out the following information for us to include with your child's records.

Patient Name: _____ **Date of Birth:** _____/_____/_____

The following person(s) have my permission to authorize medical care for my child and sign any necessary waivers on my behalf.

Name	Relationship

Please list both parents/legal guardians:_____

Please list the person(s) you would like to be an emergency contact for the patient listed above:
Name(s) and Phone Number(s):

_____

_____

Please list the person(s) you want to have access to medical records for the patient listed above:

_____

For patients 16 years and older ONLY:

Patient listed above may present and be treated unaccompanied by an adult. Yes _____ No _____

Yes ___ **No** ___ Hipp Dentistry is allowed to leave voicemails on the numbers provided on the patient registration form.

Yes ___ **No** ___ Hipp Dentistry is allowed to communicate through emails provided on the patient registration form.

Parent/Guardian Signature: _____ **Date:** _____

FINANCIALLY RESPONSIBLE PARTY

This is defined as the adult accompanying a child under the age of 18 and/or the parent or guardian of the child. This is the person who will receive the bills and correspondence.

Patient Name: _____ **Date of Birth:** _____/_____/_____

Financially Responsible Parent/Guardian

Last Name: _____ First Name: _____

Relationship to Patient: ____ Mother _____ Father _____ Other: _____

Address: _____ City/State/Zip: _____

Home Phone: _____ Work Phone: _____

Cell Phone: _____ DOB: _____/_____/_____ SSN: _____-_____-_____

Email: _____

DENTAL INSURANCE INFORMATION

Primary Insurance
Insurance Company Name:_____ Insured's Name:_____

Insured's Address: _____City/State/Zip:_____

Insured's Date of Birth: _____/_____/_____ Insured's Social Security # : _____-_____-_____

Employer _____ Employer Address _____

Secondary Insurance
Insurance Company Name:_____ Insured's Name: _____

Insured's Address:_____City/State/Zip:_____

Insured's Date of Birth: _____/_____/_____ Insured's Social Security # :_____-_____-_____

Employer _____ Employer Address _____

INSURANCE COVERAGE WAIVER

I understand that my eligibility for coverage by the insurance company named in the Dental Insurance Information section of this document may not be confirmed at this time. I wish to receive dental services from Hipp Dentistry. If it is determined that I am not eligible for coverage, I understand that I will be responsible for payment of all services provided.

Parent/Guardian Signature: _____ **Date:** _____

OFFICE POLICIES

Thank you for choosing our practice to serve your dental needs. Please take the time to read and initial each section and sign and date the bottom of this form.

_____ Full payment is due at the time of service unless arrangements have been made prior to the start of any treatment.

_____ Insurance balances are ultimately the patient's obligation. We file most primary insurances at no cost to you as a courtesy. However, insurance balances which are not paid within 60 days may be billed to you. Please keep your walk-out statements and follow up with your insurance carrier to ensure prompt payment.

_____ Some of your treatment may <u>not</u> be covered by your insurance carrier. The cost for such charges will be your responsibility.

_____ Major services may require a deposit equal to at least one half of the estimated patient portion at the time the appointment is made.

_____ Patients are asked to confirm their appointments at least 48 hours in advance by directly contacting our office or by responding to our confirmation contact (email or text). Failure to confirm your appointment may result in a $50.00 charge for the time reserved.

_____ There will be a fee of $30.00 for any checks returned as Non-Sufficient Funds (NSF).

_____ Patient balances that go unpaid for 90 days or more may incur one or more of the following charges:

- *Interest charges for 1.5% per month*
- *18% APR collection fees (up to 25% of the full balance)*
- *Legal fees for collection services*

PHOTOGRAPHY RELEASE

I, _____ authorize Evan Hipp DMD, PC to take photographs, slides, and/or videos of my face, jaws, and teeth. I understand that the photographs, slides, and/or videos will be used as a record of my care, and may be used for educational purposes in lectures, demonstrations, advertising (including website publication, newspapers, magazines, television), professional publications (dental magazines and journals, and/or social media (Facebook, etc.). I further understand that my name or other identifying information will be kept confidential. I do not expect compensation, financial or otherwise, for the use of these photographs.

ACKNOWLEDGMENT OF RECIEPT OF NOTICE OF PRIVACY PRACTICES

I, _____ have reviewed a copy of this office's Notice of Privacy Practices.

I have had full opportunity to read and consider the contents of this office's policies and Notice of Privacy Practices. I understand that I am giving permission to use and disclose my protected health information to use in treatment, payment activities, and healthcare operations. I also understand that I have the right to revoke or modify this permission.

_____

Signature of Patient/Parent or Legal Guardian Date

MEDICAL HISTORY

Patient Name: _____ **Birth Date:** _____/_____/_____

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions

Are you under a physician's care now?	Yes	No	Name of Family Physician:
Have you ever been hospitalized or had a major operation?	Yes	No	If yes, please explain:
Have you ever had a serious head or neck injury?	Yes	No	If yes, please explain:
Are you taking any medications, pills, or drugs?	Yes	No	If yes, please list medications:
Have you ever taken Phen-Fen or Redux?	Yes	No	If yes, please list medications:
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?	Yes	No	If yes, please list medications:
Are you aware of any allergic (or adverse) reaction to any medication or substance?	Yes	No	If yes, please explain:
Are you on a special diet?	Yes	No	If yes, please explain:
Do you use tobacco?	Yes	No	

WOMEN: Are you pregnant/trying to get pregnant? Y or N Taking Oral Contraceptives? Y or N Nursing? Y or N

Are you allergic to any of the following?

Aspirin Penicillin Codeine Local Anesthetics Acrylic Metal Latex Sulfa Drugs

Other If yes, please explain: _____

Do you have, or have you had, any of the following?											
A.I.D.S	Yes	No	Cortisone Medication	Yes	No	Hepatitis A, B, C	Yes	No	Rheumatic Fever	Yes	No
HIV positive	Yes	No	Diabetes	Yes	No	Herpes	Yes	No	Shingles	Yes	No
Alzheimer's Disease	Yes	No	Drug Addiction	Yes	No	High Blood Pressure	Yes	No	Sickle Cell Disease	Yes	No
Anemia	Yes	No	Easily Winded	Yes	No	Hives or Rash	Yes	No	Sinus Trouble	Yes	No
Angina	Yes	No	Emphysema	Yes	No	Hypoglycemia	Yes	No	Spina Bifida	Yes	No
Arthritis/Gout	Yes	No	Epilepsy or Seizures	Yes	No	Irregular Heartbeat	Yes	No	Stomach Disease	Yes	No
Artificial Heart Valve	Yes	No	Excessive Bleeding	Yes	No	Kidney Problems	Yes	No	Stroke	Yes	No
Artificial Joints	Yes	No	Excessive Thirst	Yes	No	Leukemia	Yes	No	Swelling of Limbs	Yes	No
Asthma	Yes	No	Fainting or Dizzy Spells	Yes	No	Liver Disease	Yes	No	Thyroid Disease	Yes	No
Blood Disease	Yes	No	Frequent Cough	Yes	No	Low Blood Pressure	Yes	No	Tonsillitis	Yes	No
Blood Transfusion	Yes	No	Frequent Diarrhea	Yes	No	Lung Disease	Yes	No	Tuberculosis	Yes	No
Breathing Problems	Yes	No	Genital Herpes	Yes	No	Mitral Valve Prolapse	Yes	No	Tumors or Growths	Yes	No
Bruise Easily	Yes	No	Glaucoma	Yes	No	Osteoporosis	Yes	No	Ulcers	Yes	No
Cancer	Yes	No	Hay Fever	Yes	No	Pain in Jaw Joints	Yes	No	Venereal Disease	Yes	No
Chemotherapy	Yes	No	Heart Attack/Failure	Yes	No	Parathyroid Disease	Yes	No	Yellow Jaundice	Yes	No
Chest Pain	Yes	No	Heart Murmur	Yes	No	Psychiatric Care	Yes	No			
Cold Sore/Fever Blister	Yes	No	Heart Pacemaker	Yes	No	Radiation Treatment	Yes	No			
Congenital Heart Disease	Yes	No	Heart Trouble/Disease	Yes	No	Recent Weight Loss	Yes	No			
Convulsions	Yes	No	Hemophilia	Yes	No	Renal Dialysis	Yes	No			

Do you now have or have you had any disease, condition, or problem not listed above? Y or N
If yes, please list: _____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

Patient Signature_____ **Date:** _____